Exhibit B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OKLAHOMA

SHAUNA EVELYN MCMURRAY, Plaintiff,	)	
vs.	)	Case Number: 08-cv-381-GKF-SAJ
SMITHKLINE BEECHAM CORP., Defendant.	)	

AFFIDAVIT IN SUPPORT OF MOTION TO COMPEL

STATE OF TEXAS)
) ss:
COUNTY OF HARRIS)

John W. Belmont, being first duly sworn, deposes and says:

1. I am a medical doctor specializing in Medical Genetics and Pediatrics. I am board certified in the areas of Pediatrics, Clinical Genetics, and Biochemical Genetics. In addition to having an active clinical genetics practice, I am involved in ongoing research in the area of genetic causes of congenital cardiovascular malformations, which has been the focus of my research and other professional activities for over twenty years.

2. I make this affidavit based on my own knowledge, training, experience, and expertise in the field of Medical Genetics and on the knowledge acquired from a review of the medical records for the minor Plaintiff I.M.

3. I have been retained in this matter by GlaxoSmithKline to conduct a genetic evaluation of I.M. to determine if a specific genetic cause of her congenital malformation could be identified.

4. Congenital cardiovascular malformations are not uncommon, occurring in approximately 1% of all live births. If mild abnormalities that often go undetected in the

absence of routine echocardiography are included, the rate of occurrence is in excess of 5% of all live births. There are several lines of evidence supporting the genetic etiology of congenital defects in general, and congenital cardiovascular malformations in particular. A genetic etiology becomes even more compelling when the child's presentation is syndromic – *i.e.*, when the child's cardiac malformation is not isolated, but is accompanied by defects in other organ systems and/or dysmorphic features.

5. Isolated or syndromic congenital cardiovascular malformations may be caused by chromosomal disorders, genomic disorders, or single gene mutations, many of which can be identified and confirmed through clinically validated testing. Due to technological advances and the rapid pace of genetic discovery, the ability to identify and detect genetic causes of cardiovascular malformations has improved dramatically, even over the last 2-3 years.

6. I.M. was born with a congenital cardiovascular malformation known as coarctation of the aorta, which was accompanied by one or more ventricular septal defects. She also had a cleft palate and a number of minor anomalies and dysmorphic features. Also reported in the medical records is the occurrence of the same heart defect (coarctation of the aorta) in one of I.M.'s uncles, and possibly in one of her cousins (it is not clear whether this is the same person previously described as I.M.'s paternal uncle, or a different family member with the same cardiovascular malformation) I.M.'s medical records also note a number of dysmorphic features, minor anomalies, and developmental delays that, in conjunction with her cardiac defect and cleft palate, are strongly suggestive of a genetic syndrome. Based on her family history and her clinical presentation, a genetic disorder or syndrome must be considered in the etiology of I.M.'s birth defects.

7. I.M.'s presentation, as described in her medical records, suggests a number of potential genetic causes for her congenital abnormalities. Many, but not all, of these can now be detected by clinically validated genetic testing. Some can only be diagnosed through observation and thorough physical examination. If I.M. were a patient in my clinic, I would recommend several types of genetic testing including high resolution chromosomal microarray analysis, and assays for various single gene mutations known to be associated with syndromes that are consistent with I.M.'s clinical presentation.

8. Not all genetics laboratories have the capability to perform every type of genetic test; various laboratories offer only a relative handful of clinically available assays to detect specific single gene mutations, and fewer still offer appropriate high resolution chromosomal microarray analysis. The tests that I would conduct cannot all be done at a single genetics laboratory. However, the volume of blood required by each laboratory would be small and all samples could be collected with a single blood draw.

9. Previous genetic testing included a karyotype, fluorescent in situ hybridization (FISH) for 22q11 deletion, and a chromosomal microarray analysis performed in 2006 at Lab Corp. The testing that I am proposing is non-duplicative and would provide genetic information that these tests could not. While I propose to run a chromosomal microarray analysis, the array that I would use is one that has only recently become available for clinical use. It has a much higher resolution than the one used by Lab Corp in 2006 and is capable of detecting chromosomal anomalies that could not have been detected using the Lab Corp array. I.M.'s medical records lack any indication that testing for any single gene disorders has been performed to date.

10. For these reasons, it is my professional opinion that further genetic testing of I.M., as described above, is medically warranted to shed light on the potential cause of her birth defects.

John W. Belmont, M.D., Ph.D.

Sworn to before me this 8 day of July, 2009

Notary Public

SHERI L WEAVER
My Commission Expires
July 24, 2009